FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021832

Facility Name: Arthur Merkle Clara Knipprath Nursing Home

Address: 1190 E 2900 North Road (Number) Clifton (City) 60927 (Zip Code)

County: Iroquois

Telephone Number: (815) 694-2306 **Fax #** (815) 694-2818

IDPA ID Number: 362841358001

Date of Initial License for Current Owners: 10/1/1975

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Brother Damien **Telephone Number:** (815) 694-2306

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Brother Damien, OSF

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Mark L Smith, President

(Firm Name & Address) Smith Koelling Dykstra & Ohm, PC, 1605 N Convent, Bourbonnais, IL 60914

(Telephone) (815) 937-1997 Fax # 815-935-0360

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	191	599	790	8
9	SNF/PED					9
10	ICF	8,158	11,142		19,300	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,158	11,333	599	20,090	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.60%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10 / 06 / 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 99 and days of care provided 599

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Hor # 0021832 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	231,824	15,841	12,451	260,116		260,116		260,116			1
2	Food Purchase		124,346		124,346	(22,952)	101,394	(8,979)	92,415			2
3	Housekeeping	60,520	276	8,640	69,436		69,436	(12,141)	57,295			3
4	Laundry	28,330	4,883	4,239	37,452		37,452		37,452			4
5	Heat and Other Utilities			128,582	128,582	(3,840)	124,742	(30,227)	94,515			5
6	Maintenance	73,462	914	13,637	88,013	(598)	87,415	(14,614)	72,801			6
7	Other (specify):* **ILU Expense**			1,500	1,500		1,500	(1,500)				7
8	**TOTAL General Services**	394,136	146,260	169,049	709,445	(27,390)	682,055	(67,461)	614,594			8
	B. Health Care and Programs											
9	Medical Director			4,300	4,300		4,300		4,300			9
10	Nursing and Medical Records	873,510	71,989	5,560	951,059		951,059	(13,500)	937,559			10
10a	Therapy	15,881		1,130	17,011		17,011		17,011			10a
11	Activities	50,133	6,403	9,339	65,875		65,875	(2,559)	63,316			11
12	Social Services	17,503			17,503		17,503		17,503			12
13	CNA Training											13
14	Program Transportation			428	428		428		428			14
15	Other (specify):* **Cost of Sundries**			4,796	4,796		4,796	(4,796)				15
16	**TOTAL Health Care and Programs**	957,027	78,392	25,553	1,060,972		1,060,972	(20,855)	1,040,117			16
	C. General Administration											
17	Administrative	75,000			75,000	8,070	83,070	(22,993)	60,077			17
18	Directors Fees											18
19	Professional Services			24,126	24,126		24,126		24,126			19
20	Dues, Fees, Subscriptions & Promotions			4,135	4,135		4,135		4,135			20
21	Clerical & General Office Expenses	88,890	3,023	6,940	98,853		98,853		98,853			21
22	Employee Benefits & Payroll Taxes			362,267	362,267	22,952	385,219	(5,821)	379,398			22
23	Inservice Training & Education			1,239	1,239		1,239		1,239			23
24	Travel and Seminar			344	344		344		344			24
25	Other Admin. Staff Transportation			1,425	1,425		1,425		1,425			25
26	Insurance-Prop.Liab.Malpractice			43,659	43,659	(232)	43,427	(2,495)	40,932			26
27	Other (specify):*											27
28	**TOTAL General Administration**	163,890	3,023	444,135	611,048	30,790	641,838	(31,309)	610,529			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,515,053	227,675	638,737	2,381,465	3,400	2,384,865	(119,625)	2,265,240			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home #0021832 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			219,182	219,182	(3,400)	215,782	(87,239)	128,543			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			219,182	219,182	(3,400)	215,782	(87,239)	128,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		77,188		77,188		77,188		77,188			39
40	Barber and Beauty Shops		8	13,562	13,570		13,570	(13,570)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		77,196	67,765	144,961		144,961	(13,570)	131,391			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,515,053	304,871	925,684	2,745,608		2,745,608	(220,434)	2,525,174			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Arthur Merkle Clara Knipprath Nursing Home
ID# #21832
Report Period 1/1/05 to 12/31/05
Schedule V Attachment - Reclassification

Food Purchase	Line 2, Col 5	($22,952)
Employee Benefits and Payroll Taxes (To reclassify employee meals)	Line 22, Col 5	22,952
Heat & Other Utilities	Line 5, Col 5	(3,840)
Maintenance	Line 6, Col 5	(598)
Insurance, Property and Liability	Line 26, Col 5	(232)
Depreciation	Line 30, Col 5	(3,400)
Administrative (To reclassify administrative costs for Brothers' residence)	Line 17, Col 5	8,070
Total Reclassification	Line 45, Col 5	$0

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,601)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,559)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	67	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(215,341)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (220,434)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (220,434)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Arthur Merkle Clara Knipprath Nursing Home

ID# 0021832

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living Unit -Maintenance Wages	$ (10,000)	6	1
2	Independent Living Unit Wages	(13,500)	10	2
3	Independent Living Unit Wages - Administration	(15,000)	17	3
4	Independent Living Unit Employee Benefits	(5,441)	22	4
5	Independent Living Unit Wages	(12,141)	3	5
6	Independent Living Unit Insurance	(2,495)	26	6
7	Independent Living Unit Depreciation	(87,306)	30	7
8	Independent Living Unit Utilities	(30,227)	5	8
9	Independent Living Unit-Supplies	(380)	22	9
10	Independent Living Unit Maintenance & Other	(4,614)	6	10
11	Independent Living Unit Food Cost	(6,378)	2	11
12	Administration Cost for Brothers' Residence	(7,993)	17	12
13	Adjust Barber & Beauty due to income received	(13,570)	40	13
14	Adj Sundried due to income received	(4,796)	15	14
15	Independent Living Unit - Other	(1,500)	7	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(215,341)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,979)	0	0	0	0	0	0	0	0	0	0	(8,979)	2
3	Housekeeping	(12,141)	0	0	0	0	0	0	0	0	0	0	(12,141)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(30,227)	0	0	0	0	0	0	0	0	0	0	(30,227)	5
6	Maintenance	(14,614)	0	0	0	0	0	0	0	0	0	0	(14,614)	6
7	Other (specify):*	(1,500)	0	0	0	0	0	0	0	0	0	0	(1,500)	7
8	**TOTAL General Services**	(67,461)	0	0	0	0	0	0	0	0	0	0	(67,461)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(13,500)	0	0	0	0	0	0	0	0	0	0	(13,500)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,559)	0	0	0	0	0	0	0	0	0	0	(2,559)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(4,796)	0	0	0	0	0	0	0	0	0	0	(4,796)	15
16	**TOTAL Health Care and Programs**	(20,855)	0	0	0	0	0	0	0	0	0	0	(20,855)	16
	C. General Administration													
17	Administrative	(22,993)	0	0	0	0	0	0	0	0	0	0	(22,993)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(5,821)	0	0	0	0	0	0	0	0	0	0	(5,821)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,495)	0	0	0	0	0	0	0	0	0	0	(2,495)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,309)	0	0	0	0	0	0	0	0	0	0	(31,309)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,625)	0	0	0	0	0	0	0	0	0	0	(119,625)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Arthur Merkle Clara Knipprath Nursing Home** **#** **0021832** **Report Period Beginning:** **1/1/2005** **Ending:** **12/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(87,239)	0	0	0	0	0	0	0	0	0	0	(87,239)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(87,239)	0	0	0	0	0	0	0	0	0	0	(87,239)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(13,570)	0	0	0	0	0	0	0	0	0	0	(13,570)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(13,570)	0	0	0	0	0	0	0	0	0	0	(13,570)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(220,434)	0	0	0	0	0	0	0	0	0	0	(220,434)	45

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Franciscan Missionary Brothers	100%	N/A				
of the Sacred Heart of Jesus						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing H(# 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bro Damien Dabraekeleer	Executive Director	Administrator	0.00	0	46	100.00	Stipend to	$ 75,000	17	1
2	Bro William Farrelly	Director	Nursing	0.00	0	44	100.00	Religious	67,500	10	2
3	Bro Joseph Ruscha	Director	Maintenance	0.00	0	44	100.00	Order	49,996	6	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 192,496		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Hor # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home **#** 0021832 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2004 report.	$	Tax Exempt	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arthur Merkle Clara Knipprath Nursing Home COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0021832

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,919 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Villas, 15 Independent Living Units - 17,005 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF	1,730,560	1975	$ 24,225	1
2	Farm/ILU	995,072	1975	32,775	2
3	TOTALS	2,725,632		$ 57,000	3

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1975	1975	$ 773,471	$ 15,244	33	$ 15,244	$	$ 639,938	4
5			1975	1975	432,948	6,190	25	6,190		406,845	5
6											6
7											7
8											8
	Improvement Type**										
9	Fixed Equipment			1981	924		5			924	9
10				1982	656		15			656	10
11				1983	5,462	22	17	22		5,298	11
12				1984	16,618		15			16,618	12
13				1985	6,098	191	15	191		5,143	13
14				1986	2,400		10			2,400	14
15				1987	6,773		25			6,773	15
16				1988	650		10			650	16
17				1979	2,032		5			2,032	17
18				1980	14,012		15			14,012	18
19				1989	9,327	388	20	388		7,161	19
20				1990	1,276		10			1,276	20
21				1991	25,219	1,231	20	1,231		18,448	21
22				1992	6,594	440	15	440		5,935	22
23				1993	2,825		10			2,825	23
24				1995	97,366	3,987	25	3,987		43,022	24
25	Fire Supression-Kitchen			1996	2,115	106	20	106		1,005	25
26	Nurses Station Impr			1996	5,395	360	15	360		3,417	26
27	Verticla Blinds-Arthur			1996	350	35	10	35		332	27
28	Heat pump compressor			1996	1,890	189	10	189		1,796	28
29	Therapy Room Cubicle			1996	321	32	10	32		305	29
30	Kitchen Heat Pump			1996	1,679	168	10	168		1,595	30
31	2 Water Heaters			1996	4,158	277	15	277		2,633	31
32	Call Light System			1996	1,348	90	15	90		854	32
33	Room Heaters			1996	3,603	360	10	360		3,422	33
34	Pump/Generator Impr			1997	2,540		5			2,540	34
35	Fire Alarm Impr			1997	1,105		5			1,105	35
36	Fire Safety Code Impr			1997	5,844	390	15	390		3,312	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Procare Nurse Call System	1997	$ 36,033	$ 2,402	15	$ 2,402	$	$ 20,419	37
38	Garbage Disposal	1998	1,142	76	15	76		571	38
39	Heat Pump	1998	2,853	285	10	285		2,139	39
40	Fire Door	1998	200	10	20	10		75	40
41									41
42	Room Heat/Cool Unit	1998	3,632	363	10	363		2,724	42
43	Generator	1998	141,059	7,053	20	7,053		52,897	43
44	Cubicle Curtains	1998	5,250	525	10	525		3,938	44
45	Register Covers	1999	1,056	106	10	106		687	45
46	Walk-in Freezer/Cooler	1999	20,126	805	25	805		5,233	46
47	Water Heater Booster	1999	1,131	113	10	113		735	47
48	Above Ground Tank	1999	1,495	149	10	149		971	48
49									49
50	Air/Heat Unit	1999	1,057		5			1,057	50
51	Air Return Extension	2000	1,532	102	15	102		562	51
52	SS Garbage Disposal	2000	527	26	20	26		145	52
53	(2) Air /Heat Units	2000	1,950	195	5	195		1,950	53
54	Resident Security System	2001	4,830	483	10	483		2,174	54
55	Sewage Component Impr	2001	4,549	303	15	303		1,365	55
56	Disposal	2001	549	55	10	55		247	56
57	Dehumidifier	2001	1,050	105	10	105		473	57
58	Chapel Heating/Cooling	2001	19,000	1,900	10	1,900		8,550	58
59	Natural Gas Hot Water Conversion	2002	29,705	1,981	15	1,981		6,932	59
60	Resident Hall Water Coolers	2002	1,657	166	10	166		580	60
61	Sewer Lagoon Impr	2002	6,824	682	10	682		2,388	61
62	Time Clock	2002	395	40	10	40		139	62
63	Resident Room Heat/Cool Unit	2003	3,470	231	15	231		578	63
64	Satellite	2003	782	156	5	156		391	64
65	Front Entrance Door	2003	3,612	361	10	361		903	65
66	Exterior Security Locks	2003	612	61	10	61		153	66
67	Closet Doors	2003	2,845	190	15	190		475	67
68	DR Rooftop Heating Unit	2003	6,325	422	15	422		1,055	68
69	Staff DR Cooling Unit	2003	2,600	173	15	173		433	69
70	TOTAL (lines 4 thru 69)		$ 1,742,847	$ 49,219		$ 49,219	$	$ 1,323,211	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,742,847	$ 49,219		$ 49,219	$	$ 1,323,211	1
2									2
3	Oxygen Room Ventilation	2004	593	59	10	59		89	3
4	Hot Water Supply - Mary Hall	2004	3,578	179	20	179		268	4
5	Water softner System	2005	9,899	495	10	495		495	5
6	New Shower Valves, All Halls	2005	3,084	77	20	77		77	6
7	Oxygen Room Sprinkler	2005	709	18	20	18		18	7
8	Water System Improvement	2005	1,241	62	10	62		62	8
9	Dishwasher Motor	2005	1,825	183	5	183		183	9
10	Heater Unit	2005	410	20	10	20		20	10
11	Well Pump Electrical	2005	1,518	51	15	51		51	11
12									12
13	Land Improvements	1975	194,467	2,900	25	2,900		166,923	13
14		1979	8,614		20			8,614	14
15		1982	42,700		11			42,700	15
16		1983	1,999		20			1,999	16
17		1984	3,405		20			3,405	17
18		1985	860		12			860	18
19		1986	6,156		15			6,156	19
20		1980	762		20			762	20
21		1992	6,346	318	20	318		4,284	21
22		1993	3,640		5			3,640	22
23		1995	6,753	412	15	412		4,331	23
24	Drive Pavement	1997	8,900	593	15	593		5,043	24
25	Well	1998	7,339	367	20	367		2,752	25
26	Sewer Improvement	1999	13,399	1,340	10	1,340		8,709	26
27	Drive Sealing	2000	8,945	894	5	894		8,945	27
28	Landscaping	2002	4,211	281	15	281		983	28
29	Drive Widening	2002	32,150	3,215	10	3,215		11,253	29
30	Sewage System Control Panel	2003	2,635	263	10	263		659	30
31	Water Well Improvement	2003	7,449	745	10	745		1,862	31
32	Drive Sealing	2004	3,996	799	5	799		1,199	32
33	Sidewalk	2005	2,268	76	15	76		76	33
34	TOTAL (lines 1 thru 33)		$ 2,132,698	$ 62,566		$ 62,566	$	$ 1,609,629	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,132,698	$ 62,566		$ 62,566	$	$ 1,609,629	1
2	Buildings	1980	4,422		20			4,422	2
3		1981	1,738		10			1,738	3
4		1982	1,106	44	25	44		1,040	4
5		1984	130,023	19	20	87	68	130,023	5
6		1985	598		15			598	6
7		1986	640,838	20,158	33	20,158		407,603	7
8	Buildings	1987	37,528		15			37,528	8
9		1988	13,228		15			13,228	9
10		1989	10,488		15			10,488	10
11		1990	2,096		10			2,096	11
12		1991	35,542	1,815	20	1,815		26,317	12
13		1992	(34,187)	(810)	40	(810)		(10,935)	13
14		1993	475		10			475	14
15	Floor Tile Nurse Station	1996	2,050	137	15	137		1,299	15
16	Floor Tile Clara Wing	1996	778	52	15	52		493	16
17	Floor Tile, Main, Kitchen	1997	14,739		7			14,739	17
18	Hallway Impr	1997	3,870		5			3,870	18
19	Roof Improvements	1997	13,828	922	15	922		7,836	19
20	Floor Tile Arthur Wing	1998	6,475	647	10	647		4,856	20
21	DR Vinyl Floor	1998	4,420		5			4,420	21
22	Interior Coridor Doors	2000	2,415	161	10	161		886	22
23	Chapel Roof (Partial)	2001	3,099	206	15	206		929	23
24	Kitchen Doors	2001	1,031	103	10	103		464	24
25	New Roof	2002	32,319	1,616	20	1,616		5,656	25
26	Floor Tile	2002	2,919	195	15	195		682	26
27	Maintenance Shed	2002	7,010	280	25	280		981	27
28	North Wing Roof	2003	34,539	1,727	20	1,727		4,317	28
29	Chapel Windows	2003	18,234	911	20	911		2,279	29
30	Resident Room Tiling	2003	1,521	152	10	152		380	30
31	Chapel Entry Flooring	2003	2,924	292	10	292		731	31
32	Chapel Roof/Glass	2004	3,115	208	15	208		312	32
33	Tiling Mary Hall	2004	36,035	3,604	10	3,604		5,406	33
34	TOTAL (lines 1 thru 33)		$ 3,167,914	$ 95,005		$ 95,073	$ 68	$ 2,294,786	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,167,914	$ 95,005		$ 95,073	$ 68	$ 2,294,786	1
2	Mary Hall Rehab	2004	7,660	511	15	511		766	2
3	Mary Hall Wiring	2004	3,050	153	20	153		229	3
4	Dining Area Painting	2005	1,875	188	5	188		188	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,180,499	$ 95,857		$ 95,925	$ 68	$ 2,295,969	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Arthur Merkle Clara Knipprath Nursing Home
ID# 21832
Report Period Beginning 1/1/05 to 12/31/05
Attachment to Schedule XI, Page 12B, Line 25

The Nursing Home received an adjustment on building improvements constructed in 1982 due to construction problems relating to leakage in the chapel roof. This amount is reflected as a 1992 line item and adjusted prospectively.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 214,700	$ 21,198	$ 21,198	$		$ 98,825	71
72	Current Year Purchases	60,212	5,527	5,527			5,527	72
73	Fully Depreciated Assets	194,881					194,881	73
74								74
75	TOTALS	$ 469,793	$ 26,725	$ 26,725	$		$ 299,233	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1996 Ford Eldorado Transit	1996	$ 38,099	$ 3,810	$ 3,810	$	10	$ 36,194	76
77	Facility Business	1996 Mercury Sable	1996	15,878				4	15,878	77
78	Patient Transport	1993 Mercury Villager	1992	18,387				5	18,387	78
79	Maintenance Truck	1997 GMC Truck	2002	14,580	2,083	2,083		7	7,290	79
80	TOTALS			$ 86,944	$ 5,893	$ 5,893	$		$ 77,749	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,794,236	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,475	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,543	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 68	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,672,951	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Brother Residence	$ 95,606	$ 2,410	$ 72,337	86
87	Brother Residence Equipment	22,663	990	15,094	87
88	Apartment Complex Bldg	1,791,233	53,052	716,370	88
89	Apartment Complex Equipment	727,451	32,986	464,303	89
90	Apartment Complex Land Imp	22,337	1,269	15,230	90
91	TOTALS	$ 2,659,290	$ 90,707	$ 1,283,334	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

All new nurses aids are required to have completed the proper certification and training prior to being hired.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			57,342			57,342	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			18,928			18,928	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39-2				918			918	13
14	TOTAL			$		$ 77,188	$		$ 77,188	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home **#** 0021832 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,741	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,000)	396,564		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	965,335		5
6	Prepaid Insurance	27,768		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued interest	27,030		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,481,438	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,071,678		12
13	Land	442,568		13
14	Buildings, at Historical Cost	3,708,112		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,297,385		16
17	Accumulated Depreciation (book methods)	(3,950,783)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,568,960	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,050,398	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,234	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,106		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,540		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Apartment Rental Deposits	16,380		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 161,260	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 161,260	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,889,138	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,050,398	$	48

***(See instructions.)**

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home **#** 0021832 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,900,363	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,900,363	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(11,225)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (11,225)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,889,138	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,288,055	1
2	Discounts and Allowances for all Levels	(914,041)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,374,014	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,428	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,428	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,452	13
14	Non-Patient Meals	8,554	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,006	23
	D. Non-Operating Revenue		
24	Contributions	12,864	24
25	Interest and Other Investment Income***	87,536	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 100,400	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental and Farm	216,535	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 216,535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,734,383	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	709,445	31
32	Health Care	1,060,972	32
33	General Administration	611,048	33
	B. Capital Expense		
34	Ownership	219,182	34
	C. Ancillary Expense		
35	Special Cost Centers	90,758	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,745,608	40
41	**Income before Income Taxes (line 30 minus line 40)****	(11,225)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (11,225)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,045	2,205	$ 57,235	$ 25.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,767	9,790	208,884	21.34	3
4	Licensed Practical Nurses	11,329	12,553	206,619	16.46	4
5	CNAs & Orderlies	39,064	41,960	400,284	9.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,560	1,704	18,316	10.75	8
9	Activity Director	1,217	1,401	16,558	11.82	9
10	Activity Assistants	3,108	3,484	34,907	10.02	10
11	Social Service Workers	1,582	1,726	17,969	10.41	11
12	Dietician					12
13	Food Service Supervisor	1,545	1,729	33,399	19.32	13
14	Head Cook	1,451	1,643	20,237	12.32	14
15	Cook Helpers/Assistants	17,683	19,259	184,482	9.58	15
16	Dishwashers					16
17	Maintenance Workers	4,092	4,324	65,148	15.07	17
18	Housekeepers	5,520	6,001	63,532	10.59	18
19	Laundry	2,912	3,167	27,679	8.74	19
20	Administrator	2,496	2,496	61,594	24.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,545	6,170	74,541	12.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,336	23,669	10.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,996	121,948	$ 1,515,053 *	$ 12.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	111	$ 5,103	Ln 1,Col 3	35
36	Medical Director	36	4,300	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	600	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	877	Ln 11, Col 3	44
45	Social Service Consultant	9	877	Ln 11, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	201	$ 11,757		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	None	$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brother Damien	Administrator	0	$ 75,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Smith Koelling Dykstra & Ohm	Accounting and Audit	$ 18,995
Premier Data	Payroll Services	2,172
Boston Financial	Retirement Plan Consult	866
American Appraisal	Fixed asset record-keeping	1,630
Other	Fees	463
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,126

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,882
Unemployment Compensation Insurance	
FICA Taxes	109,816
Employee Health Insurance	216,748
Employee Meals	22,952
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 379,398

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 18)	288
Life Services Network	3,597
Dept of Professional Regulation	100
Catholic Health Association Dues	100
Dept of Health Services	50
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
District DMA	99
Seminar Expense	
LTC Seminar - St Loius	245
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 344

**See instructions.

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **$3,597 Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.62**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,306** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,306**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **22,952** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,601**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **67**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Smith Koelling Dykstra & Ohm, PC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Arthur Merkle Clara Knipprath Nursing Home
ID# 21832
Report Period Beginning 1/1/05 Ending 12/31/05
Attachment to Schedule XX, Item 14

The portion of the building which is used for Independent Living Units is a completely separate section of the building with its own meters for utilities. Expenses, including depreciation, which relate to the Independent Living Units, are maintained separately in the accounting records.

12/31/2005

STATE OF ILLINOIS

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home 21832

Diagnostic Report

				DIFFERENCE
Salary/Wages	Page 4, Line 45, Col 1		1,515,053	
	Page 20, Line 34, Col 3		1,515,053	0
Book Depreciation	Page 4, Line 30, Col 4		219,182	
Care Related Depr	Page 13, Line 82	128,475		
Non-Care Depr	PAGE 13, LINE 91, COL 3	90,707	219,182	0
Adjusted Depr	PAGE 4, LINE 30, COL 8		128,543	
	PAGE 13, LINE 83		128,543	0
Interest	PAGE 4, LINE 32, COL 3	0		
	PAGE 9, LINE 15, COL 10	0		0
Adjustments	PAGE 4, LINE 45, COL 7		(220,434)	
	PAGE 5, LINE 30, COL 1		(220,434)	0
Administrative Salaries	PAGE 3, LINE 17, COL 4		75,000	
				0
	PAGE 21, SCHED A		75,000	
PROFESSIONAL SERVICES	PAGE 3, LINE 19, COL 4		24,126	
	PAGE 21, SCHED C		24,126	0
DUES & SUBCRIPTIONS	PAGE 3, LINE 20, COL 8		4,135	
	PAGE 21, SCHED F		4,135	0
EMPLOYEE BENEFITS	PAGE 3, LINE 22, COL 8		379,398	
	PAGE 21, SCHED D		379,398	0
TRAVEL & SEMINAR	PAGE 3, LINE 24, COL 8		344	
	PAGE 21, SCHED G		344	0
DEPRECIATION-COST	PAGE 13, SCHED E, LINE 81		3,794,236	
	PAGE 11, SCHED A, LINE 3	57,000		
	PAGE 12, LINE 34, COL 4	3,180,499		
	PAGE 13, LINE 75, COL 1	469,793		
	PAGE 13, LINE 80, COL 4	86,944	3,794,236	0
DEPREC - CURRENT BK	PAGE 13, SCHED E, LINE 82		128,475	
	PAGE 12, LINE 34, COL 5	95,857		
	PAGE 13, LINE 75, COL 2	26,725		
	PAGE 13, LINE 80, COL 5	5,893	128,475	0
DEPREC - STRAIGHT LINE	PAGE 13, SCHED E, LINE 83		128,543	
	PAGE 12, LINE 34, COL 7	95,925		
	PAGE 13, LINE 75, COL 3	26,725		
	PAGE 13, LINE 80, COL 6	5,893	128,543	0
DEPREC - ADJUSTMENTS	PAGE 13, SCHED E, LINE 84		68	
	PAGE 12, LINE 34, COL 8	68		
	PAGE 13, LINE 75, COL 4	0		
	PAGE 13, LINE 80, COL 7	0	68	0
ACCUMULATED DEPR	PAGE 13, SCHED E, LINE 85		2,672,951	
	PAGE 12, LINE 34, COL 9	2,295,969		
	PAGE 13, LINE 75, COL 6	299,233		
	PAGE 13, LINE 80, COL 9	77,749	2,672,951	0
BALANCE SHEET	TOTAL ASSETS-PAGE 17, LINE 25		6,050,398	
	TOTAL LIAB-PAGE 17, LINE 48		6,050,398	0
EQUITY	TOTAL EQUITY, PAGE 17, LINE 47		5,889,138	
	ENDING EQUITY, PAGE 18, LINE 24		5,889,138	0